Neutral Citation Number: [2024] EWCOP 61 (T3)

Case No: COP20001737

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 30/10/2024

Before :

VICTORIA BUTLER-COLE KC
sitting as a Deputy Judge of the High Court

Between :

CARDIFF AND VALE UNIVERSITY HEALTH BOARD — **Applicant**

- and -

NN
(BY HER LITIGATION FRIEND THE OFFICIAL SOLICITOR) — **Respondent**

- -

Mr Thomas Jones (instructed by **NHS Wales Shared Services Partnership**) for the **Applicant**
Ms Katie Scott (instructed by **Official Solicitor**) for the **Respondent**

Hearing dates: 12 September 2024

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Approved Judgment

This judgment was handed down remotely at 10.30am on 30 October 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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VICTORIA BUTLER-COLE KC

This judgment was delivered in public but a transparency order is in force. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the respondent and members of her family must be strictly preserved. All persons, including representatives of the media and legal bloggers, must ensure that this condition is strictly complied with. Failure to do so may be a contempt of court.

Victoria Butler-Cole KC :

1. On 16 August 2024, the Cardiff and Vale University Health Board made an application seeking an order in respect of a patient in their care, detained under s.3 MHA 1983, NN. The application sought '*an order declaring that it is lawful and in NN's best interests to be offered a termination and that, in the event she chooses to proceed with the procedure, that the treatment plan is lawful and in her best interests*'. The accompanying grounds in support of the application explained that "*Whilst the proposal is to only proceed with the termination and Treatment Plan if NN decides to do so, the Treatment Plan acknowledges that there may be a need to restraint and/or sedation in the event of non-compliance after the process has reached an irreversible point*."

2. At the date of issue, NN was around 18 weeks into her pregnancy. By the time of the hearing before me, she was 21 weeks and four days. She had been expressing a wish for a termination of pregnancy since around 8 June, although this had not always been consistent. At the time of the hearing on 12 September, there were only a few days left in which the termination could take place having regard both to the time limits in the Abortion Act 1967, and the practical arrangements required for the procedure to take place locally.

3. I therefore gave my decision with very brief reasons at the conclusion of the hearing, made a declaration pursuant to s.15 MCA 2005 that NN lacked capacity to decide whether to have a termination of pregnancy, and authorised those aspects of an amended treatment plan which engaged NN's rights under Article 5 ECHR. The treatment plan made clear that it was NN's choice whether to have a termination or not, and that no best interests decision would be made for her, notwithstanding her lack of capacity. The court's intervention was only required insofar as, having chosen to have a termination and embarked on the process, NN reached a point in the medical procedure where it would pose a serious risk to her health if she were then to refuse further medical monitoring and intervention.

4. This judgment, which sets out the more detailed reasons for my decision and deals with a costs application by the Official Solicitor against the Health Board is being handed down some seven weeks later.

5. I am grateful to Ms Scott and Mr Jones for their submissions on the day of the hearing and the written submissions received subsequently addressing the issue of delay and costs. NN did not attend the hearing and did not take up an offer of a remote judicial visit. NN's mother, MM, who has supported her daughter over many years, attended remotely. She was not a party to the proceedings, but she and NN's grandmother had provided their views directly to the Official Solicitor's caseworker.

Background

6. NN is 32 years old. She has a history of substance abuse and a longstanding diagnosis of schizophrenia. Since the age of 17, she has been detained under the Mental Health Act 1983 repeatedly, and was so detained at the time of the hearing. She has been homeless since 2023, living in very difficult conditions. There are concerns on the part of the local authority and her assigned social worker that she is in a coercive and controlling relationship and has been subject to domestic abuse and exploitation linked to her partner's substance misuse. It is hoped she will be admitted to a long-term

placement at a rehabilitation service on discharge from her current detention under the MHA 1983.

7. On 13 February 2024, NN was discharged from detention under s.3 MHA 1983, but soon relapsed, failing to attend appointments with professionals and returning to the use of illicit drugs. On 16 May 2024 she was assessed and a decision made to detain her again under the MHA, but she absconded before the decision could be implemented. On 24 May 2024 she was found by police officers and brought to hospital where a urine test showed that NN had taken cocaine and methadone. A pregnancy test was carried out on admission which was positive. While NN was initially happy to discover she was pregnant, within a few days she was reported as saying she did not want the baby and on 8 June 2024 NN said that she wanted a termination. On 13 June 2024 it was confirmed by ultrasound scan that NN was eight weeks and four days pregnant.

8. The Health Board helpfully filed a document setting out all the entries in NN's medical records where she expressed a view about whether she wanted a termination or wanted to keep the baby. It shows that at various points in May and early June, NN did not believe she was pregnant, having previously accepted the positive test result. Following the ultrasound scan on 13 June, NN understood she was pregnant, although she was not always able to remember how far the pregnancy had progressed. On 25 June, NN was able to give a reasoned account of her wish to have a termination, saying she was not in a stable relationship and would not be able to give a child a good life, and that she would not be able to cope if the baby was removed from her care. She maintained that clear view the following day, but on 27 June NN told a staff nurse that the hospital had caused her to be pregnant and that she needed to go to her partner's house so they could look after the baby together. NN's views continued to fluctuate in July, at times she would say she wanted to have the baby, but after discussions with professionals about the reality of being a mother and the possibility of the baby being removed from her care, she would confirm that she wanted a termination. It is evident that NN was struggling to make a decision, and was concerned about a range of factors including what her family might think if she chose to have a termination. It is equally evident that at times, NN was confused about basic matters concerning her pregnancy. On 16 July, NN said she was sure she wanted a termination, that her grandmother would help explain her wishes if NN got mixed-up or was not able to communicate what she felt, and that '*the sooner it happens the better for me*'. NN's wish to have a termination was then consistently expressed, with NN even chasing staff to find out why a date for the procedure had not been set. On 30 July, NN told the deputy ward manager that she did not want a termination and that she had only said she did in order to get unescorted leave. Yet by 2 August, NN was again asking why the appointment for her termination had not been booked and her wish to have the termination remained consistent thereafter. These proceedings were issued on Friday 16 August 2024.

Abortion Act 1967

9. NN's treating clinicians have formed the view that the provisions of s.1(1)(a) Abortion Act 1967 are met, such that the continuation of NN's pregnancy would involve risk of injury to her mental health greater than if the pregnancy were terminated, and I have therefore proceeded on the basis that a termination for NN would be lawful (**Re X (A Child) *[2014] EWHC 1871 (Fam)*, 139 BMLR 142**).

Capacity

10. The Health Board's application included evidence from NN's consultant psychiatrist, Dr T, who considered that NN lacked capacity to conduct these proceedings and to make decisions about a termination of pregnancy. NN had clearly stated that she did not want a surgical termination of pregnancy, and by the time of the application, it was too late for a surgical termination to be carried out locally in any event, so the evidence was focused on NN's understanding of a medical termination. Dr T explained that NN's cognitive abilities had been negatively affected by her longstanding drug use and her mental illness, and that she found it difficult to concentrate and to retain information. Dr T's view was that NN did not understand what a medical termination involved or the risk of complications. In oral evidence, Dr T told me that a few weeks previously, NN had told her she thought the fetus would '*melt away*', and that the week before the hearing NN had not been able to recall that she was 20 weeks pregnant, thinking the correct figure was 8 weeks.

11. As regards capacity to conduct proceedings, Dr T said that NN had not been able to understand the information provided to her about the court process, and had said she would participate in the proceedings.

12. Dr R, the consultant obstetrician and gynaecologist involved in NN's care, explained that NN had not appeared to understand the realities of a medical termination, suggesting that it would be no worse than having a normal menstrual period. In fact, as Dr R explained, the medical termination would necessitate an in-patient stay in hospital, of uncertain duration. There would be at least two and possibly more medications to be taken at specific intervals. There was likely to be prolonged pain and heavy bleeding, as NN would deliver a fetus of advanced gestation. There were risks of the procedure including the possibility of haemorrhage and infection, and surgery might be required.

13. NN was clear to Dr R that she did not want a surgical termination, as she did not want a general anaesthetic. Dr R had explained to NN that it might become necessary for her to have surgery as a life-saving procedure, but NN did not respond. Dr R felt that although on one occasion NN had attended her clinic and proactively asked for a termination, NN had downplayed the information she was being given about the procedure.

14. The Official Solicitor was granted permission to instruct an independent psychiatrist to assess NN's capacity to make relevant decisions. Dr Martucci provided a report to the court and gave oral evidence. She had met NN online, and, in common with Dr R, had found that NN was not able to focus on the topic of discussion and would go off on a tangent. NN told Dr Martucci that she wanted a termination, but was not able to elaborate on that decision. Dr Martucci's impression was not that NN was refusing to speak about it, but that she was unable to bring to mind the information she had been provided with about the procedure. Dr Martucci formed the view that NN did not appreciate the finality of a termination, based on the answers she gave to Dr Martucci's questions. However, having seen an attendance note of the agent sent on behalf of the Official Solicitor to speak to NN, Dr Martucci agreed that in fact there was evidence that NN did understand that a termination of pregnancy was final. Dr Martucci considered, having seen the attendance note, that NN had a better grasp of what would happen than had been apparent in her own discussion with NN. Overall though, Dr

Martucci maintained her opinion that NN did not have capacity to make a decision whether to have a medical termination of pregnancy as NN did not have an adequate appreciation of the impact of the procedure, both physically and potentially on her mental health. NN had a black and white view that the termination would be good for her mental health, and continuing the pregnancy would be bad for her mental health, when the true picture was more nuanced.

15. Dr Martucci's inability to engage NN in the assessment had been predicted by NN's mother, who told the Official Solicitor's caseworker that even as NN's mother, she could only speak to NN for 10 minutes at a time, perhaps as long as 30 minutes, but that the situation was very variable. MM said that NN's understanding was sometimes good, and sometimes bad, but that NN had told her she wanted to '*get rid of the baby and have a tablet*'. MM thought it possible that NN believed there was a '*magic pill*' that would '*make it all go away*' and was distressed by the delay in a decision being made, saying "*This should've happened weeks and weeks ago and never been allowed to get to the stage where NN is in the second trimester*."

16. In her discussion with the Official Solicitor's agent on 28 August, NN said that she wanted a termination and knew what it would involve, but did not want to speak to anyone about it. NN engaged much more effectively with the solicitor who she met in person than she had with the independent psychiatrist who assessed her capacity online. She was able to give an explanation in very simple physical terms of what would happen after she took the medication. She thought she was about 19 weeks pregnant, which was not correct. She thought that her mental health would be better if she had the termination, and that the baby would probably be taken off her in any event. The Official Solicitor's agent noted that it was difficult to keep NN to the topics under discussion.

17. I accept the conclusions of Dr T, Dr R and Dr Martucci that NN lacks capacity to make this decision. She has a limited understanding of what a medical termination will involve for her at this relatively advanced stage of pregnancy, and has not been able to take on board and weigh up all the pertinent negative aspects of the procedure, or the possible impacts on her mental health of deciding one way or the other. Her inability or unwillingness to discuss the information relevant to the decision in any detail was not just due to the personal nature of the decision, or denial about the need to make a decision, but, on the balance of probabilities, due to her difficulties in consistently being able to retain and use information she had been given, as a result of her mental disorder. I agree with Ms Scott on behalf of the Official Solicitor that this is a finely balanced decision, but I am satisfied on the evidence before the court, as is the Official Solicitor, that the Health Board has discharged the burden of proof on the balance of probabilities. I further consider that as there is evidence that NN's decision-making abilities fluctuate from day to day, and because the nature of the procedure and her likely experience have not been taken on board by NN, it is entirely possible that at times during the medical termination procedure when decisions need to be made, NN will not be able to bring to mind or use information she is given by medical professionals as a result of her mental disorder. Thus, even if I was wrong to accept that NN lacked capacity to make relevant decisions at the date of the hearing, I was satisfied that there was a real prospect of NN lacking capacity at a future point. There was no time to adjourn the hearing for NN to be assisted to consider the proposed amended treatment plan and to give her views as to its provisions at a point when she was able to engage with these matters.

Treatment plan

18. The Health Board did not invite the court to make a decision as to whether a medical termination was in NN's best interests, as the clear position of all the medical professionals involved was that the termination would be offered to NN, but it would be up to NN whether to proceed. If NN chose to have the termination, it would be carried out in her best interests and in accordance with her wishes. The court's determination of her best interests was not required in those circumstances, as there was no dispute and no conflict with NN's preferences. Unfortunately, the Health Board's application was not clear on this point, stating that a declaration was sought that offering NN a termination was lawful and in her best interests, and a declaration in the same terms regarding the entirety of the treatment plan for a medical termination.

19. In fact, as became evident at the hearing before me, the court's authorisation was only sought in respect of the elements of the proposed treatment plan that constituted a deprivation of NN's liberty. The treatment plan filed with the Health Board's application did not fully identify these aspects, and more detailed information was obtained in oral evidence from Dr R. The Health Board produced an amended treatment plan on the day of the hearing in light of that evidence, which provided that if NN had taken the first medication (mifepristone) and the first dose of the second medication (misoprostol), she would be required to remain in hospital until the fetus had been delivered. If NN became agitated and tried to leave, her familiar mental health nurses who had accompanied her to the general hospital would encourage her to remain and to accept the necessary medical monitoring and intervention. If necessary, and as a last resort to protect NN's health, limited physical restraint could be used in order for a sedative to be administered to NN. Although difficult to predict the timing of events, it was possible that NN might need to be prevented from leaving the general hospital for up to 36 hours. If however NN took the first medication but refused the second, no coercive steps would be taken. In the event that NN suffered heavy bleeding, a partial delivery or other complication and would not co-operate with a plan for surgery, she would be sedated and surgery carried out under general anaesthetic.

20. Dr R said in oral evidence that if any patient had taken the first medication and the first dose of the second medication and then tried to leave the hospital, the doctors would intervene to protect the patient given the risk to their life of being without medical monitoring. It was clear to the Official Solicitor and to the court, that the proposed steps were in NN's best interests and a proportionate response to the serious risks involved. NN's consistent wish in the weeks leading up to the hearing was to have a termination of pregnancy and she had expressed frustration that it was taking so long to implement her choice. If having got to a stage in the procedure where the end of the pregnancy was inevitable, NN refused medical support and monitoring, there would be a serious risk of harm to her. Although NN had said she did not want a general anaesthetic, that was in connection with the type of termination, not in a situation where her life was at risk due to medical complications if she refused surgery. It was manifestly in NN's best interests to be protected from serious physical harm during the procedure, and from the psychological harm that would result from going through the later stages of a medical termination without pain relief and support from trained medical professionals.

21. I accepted the submissions of the parties that the elements of the treatment plan that would be invoked if NN had taken the first dose of the second medication but was not

willing to remain in hospital to receive care would engage Article 5 ECHR. The Official Solicitor submitted, applying ***R(F)v Inner South London Senior Coroner*** *[2017] EWCA Civ 31*, that since a capacitous woman would be able to leave the hospital and refuse surgery for any reason, the treatment proposed for NN was materially different to that which would be given to a person of sound mind. There was not time at the hearing to consider in any detail whether, as Dr R had said, doctors would in fact intervene to protect the life of any patient in such circumstances and if so, the legal basis for such intervention.

22. I also accepted the submissions of the parties that NN was not ineligible to be deprived of her liberty in the event the restrictive elements of the treatment plan were implemented, notwithstanding her detention under s.3 MHA 1983, following the decisions in ***Manchester University Hospital NHS Foundation Trust v JS*** [2023] EWCOP 33; ***A Hospital NHS Trust v KL*** [2023] EWCOP 59 and ***A Mental Health NHS Foundation Trust v CD (by her litigation friend the Official Solicitor)*** [2015] EWCOP 74.

Events following the hearing

23. I was informed after the hearing by the Health Board that NN immediately went ahead with her choice to have a medical termination. She was offered and accepted one dose of a sedating medication. She accepted the pain relief offered to her and did not try to leave the hospital. The measures amounting to a deprivation of liberty in the proposed treatment plan were not needed. NN stayed in the hospital for just under 24 hours before returning to the psychiatric unit. NN's Responsible Clinician reports that she is doing well since the termination.

Costs

24. In written submissions on behalf of the Official Solicitor, Ms Scott contended that the Health Board had delayed unreasonably in issuing proceedings, and sought an order that the Health Board pay 100% of the costs the Official Solicitor had incurred. The Health Board accepted there was a delay, but disputed that there should be any order for costs beyond the usual order reflecting an agreement on the part of the Health Board to pay 50% of the Official Solicitor's costs.

25. The relevant legal framework is as follows. Section 55 of the Mental Capacity Act 2005 ("MCA") provides:

> (1) Subject to Court of Protection Rules, the costs of and incidental to all proceedings in the court are at its discretion.
>
> (2) The rules may in particular make provision for regulating matters relating to the costs of those proceedings, including prescribing scales of costs to be paid to legal or other representatives
>
> (3) The court has full power to determine by whom and to what extent the costs are to be paid…"

26. COPR 2017 r19.3 provides that in welfare proceedings, the general rule is no order for costs. COPR r19.5 provides that the court may depart from that general rule if the

circumstances so justify and in deciding whether departure is justified the court shall have regard to all the circumstances including:

(1) (a) the conduct of the parties;

(b) whether a party has succeeded on part of that party's case, even if not wholly successful; and

(c) The role of any public body involved in the proceedings.

(2) The conduct of the parties includes—

(a) conduct before, as well as during, the proceedings;

(b) whether it was reasonable for a party to raise, pursue or contest a particular matter;

(c) The manner in which a party has made or responded to an application or a particular issue;

(d) whether a party who has succeeded in that party's application or response to an application, in whole or in part, exaggerated any matter contained in the application or response; and

(e) any failure by a party to comply with a rule, practice direction or court order."

27. By COPR r19.6, various provisions of the Civil Procedure Rules concerning costs also apply in the Court of Protection. Part 44 of the CPR gives the court a very wide discretion in relation to the form of the costs orders it may make and includes rules about the standard and indemnity basis of costs assessment. The court's relevant powers in relation to misconduct are set out at CPR r44.11:

"(1) The court may make an order under this rule where –

(a) a party or that party's legal representative, in connection with a summary or detailed assessment, fails to comply with a rule, practice direction or court order; or

(b) it appears to the court that the conduct of a party or that party's legal representative, before or during the proceedings or in the assessment proceedings, was unreasonable or improper.

(2) Where paragraph (1) applies, the court may –

(a) disallow all or part of the costs which are being assessed; or

(b) order the party at fault or that party's legal representative to pay costs which that party or legal representative has caused any other party to incur."

28. On behalf of the Official Solicitor, Ms Scott submits that the decision of Poole J in ***Re GH (Mastectomy: Best Interests: Costs)*** [2023] EWCOP 50 establishes a general principle that a failure to issue an application in the Court of Protection in relation to a question of serious medical treatment within a reasonable time may justify a departure

from the general rule as to costs even if another party's costs may not have been avoided had the application been brought timeously. She submits that this is such a case, having regard to the length of the delay and the impact on NN.

29. Ms Scott points out that NN first stated she wanted a termination on 8 June, when she was about 8 weeks pregnant, and that on 21 June 2024 a professionals meeting was held at which it was noted to be highly likely that an application to the Court of Protection would be required, and therefore the Health Board's legal team would need to be notified. At that stage, the view of the medical professionals was that as NN was saying she did not want a surgical termination, the termination would need to take place within the next 3 weeks. There was a recognition that NN's decision-making abilities appeared to fluctuate, as did her expressed views about whether she wanted a termination. Capacity assessments were therefore required, and as part of this process, NN needed to be told about the risk that her baby might be removed from her care after birth. There was no discussion as to what the court would be asked to determine – the minutes of a safeguarding meeting held later the same day simply record "*If all in agreement that lacks capacity to make this decision but voicing that she wants termination – needs to be a BID made by court due to personal nature of decision*". The Official Solicitor submits that an application should have been made by 28 June 2024, a week after this meeting.

30. Although the notes from 21 June 2024 record a plan to reconvene a few days later, there was then a gap until 19 July. I am told by the Health Board that from 21 to 28 June, the perinatal mental health team and the midwife were not permitted access to the ward to see NN due to infection prevention and control measures. Between 1 and 8 July, NN refused to participate in meetings or appointments scheduled to discuss the option of a termination, suggesting to medical professionals that she may have changed her mind about wanting a termination. It was not until 16 July that NN attended the Pregnancy Advice Service clinic and engaged with a discussion about having a termination. Mr Jones on behalf of the Health Board says in his written submissions that "*the Health Board considers this to have been the turning point, from which it was possible to consider NN's capacity regarding a termination in an informed way and prepare a treatment plan.*"

31. On 19 July, when the next professionals meeting was held, NN was 13 weeks and five days into her pregnancy. No-one from the legal department was present at this meeting. The professionals agreed that NN lacked capacity to make a decision about a termination and again, the minutes record the view that a decision would have to be made by the court as NN lacked capacity.

32. On 30 July 2024 there was a best interests meeting at which again no legal representative was present. NN was now 15 weeks and 4 days into her pregnancy. The consensus view remained that NN lacked capacity to decide to have a termination. The professionals, together with NN's mother who called into the later part of the meeting, agreed that a termination reflected NN's wishes and was in her best interests. Importantly, NN's mother was told that no restraint would be used if NN changed her mind. There is no suggestion in the minutes of that meeting that anyone was suggesting that a termination would be imposed on NN against her wishes. At that stage, the option of a surgical termination was still possible – such procedure being available in a hospital local to NN until 3 August, after which she would have to travel to a specialist centre.

The minutes record that an application to the Court of Protection would be made as soon as possible.

33. The application was not in fact made until 16 August 2024.

34. A remote hearing for initial directions took place on 20 August 2024. The Official Solicitor was given permission to instruct an independent consultant psychiatrist on the question of NN's capacity. A final hearing was listed for 12 September 2024, just over 3 weeks later, and 2 days before the last possible date on which NN could have a medical termination locally.

35. Is the Official Solicitor correct to contend that an application should have been made promptly after 21 June 2024 and in any case by 28 June 2024? The Health Board says not, because further discussions were needed with NN after the meeting on 21 June, and capacity assessments had to be carried out. The delay in these steps being taken was due to NN's non-engagement. More importantly, Mr Jones submits that the medical professionals "*would not have been meeting their professional obligations to proceed with seeking authority from the court to proceed with NN's termination given that an application at that stage, with the obtaining of all of the necessary documentation, could have put undue pressure on NN*." The medical professionals would have needed to satisfy themselves that the requirements of s.1 Abortion Act 1967 were met, as well as assessing NN's capacity and ascertaining her wishes.

36. Choosing to have a termination, whether a decision made with capacity or not, is a significant one for any woman. Any woman, regardless of whether they have a mental disorder, would want time to think and to reach a settled view, and even having done so, might yet change their mind. It would be unconscionable for any pressure to be put on a woman facing that choice, whether by medical professionals or a court. Information about the options for termination, and the realities of continuing with the pregnancy or having a termination need to be provided, and the woman given an opportunity to discuss them and to ask questions. Where the woman in question is a detained psychiatric patient whose capacity is in question, it is not surprising that this process may take longer than for other women. In my judgment, it was reasonable for the clinicians to seek further discussions with NN after 21 June before reaching a concluded view about her capacity and whether she had a settled wish to have a termination. It is unfortunate that infection control measures apparently prevented this from happening for a week, and even more unfortunate that it was not until 16 July that NN attended the clinic.

37. When it was recognised on 21 June 2024 that the legal team would need to be involved, in my view, that should have happened swiftly. Members of the legal team should then have been present at further meetings to advise the clinicians about what evidence was required for a court application and, crucially, to focus the minds of the professionals on what it was that the court was going to be asked to decide. If the legal team had been involved in those meeting, then on 16 July 2024 when the plans for NN became clearer, it should have taken less time for an application to be issued. The Health Board explains that there were staff absences due to annual leave over the summer break which explain the delay in issuing the application. In the circumstances of this case, where every day that passed meant that the options for NN narrowed, and NN herself had to continue with a pregnancy she had decided she did not want, four weeks was simply too long. In my judgment, an application should have been prioritised and made at the

very latest by 26 July 2024. If it had been, a decision would likely have been made by the court by mid-August, rather than mid-September. While that may not have made any difference to the type of termination NN had, it would have saved her a month of waiting and wondering why her expressed wishes were not being acted on as her pregnancy progressed, and it would have meant that the procedure she underwent had lower risks of physical or mental harm.

38. Given the changes in NN's expressed wishes over a period of time, it was always possible that any court application would need to be withdrawn. That would have meant that costs were incurred unnecessarily by the parties, which is undoubtedly a negative factor. But given the particular need for speedy decision-making in this area of medical treatment, it would have been better to err on the side of caution and issue proceedings earlier. It is also apparent on reading the accounts of NN's expressed wishes that her more persistent wish was to have a termination, and that this was the view she expressed on the occasions when she was able to have a sustained discussion about the options open to her, and for which she was able to give reasons.

39. The Health Board contends that part of the delay in obtaining a decision from the court was due to the Official Solicitor requiring an independent expert and additional evidence. The directions proposed by the Health Board on issue of the proceedings would have resulted in a final hearing being held by 27 August 2024, in line with the guidance of Arbuthnot J in ***A Health Board v AZ (Termination of Childhood Pregnancy: Guidance)*** [2023] EWHC 2517 (Fam). That was a case concerning an 11 year old child, Arbuthnot J said that an application seeking authority to carry out a termination of pregnancy on a non-competent child "*should be regarded as a medical treatment issue of the utmost urgency*", in light of the time limits in the Abortion Act 1967, the increased complexity and risk of terminations at a more advanced gestation, including risks of complications and of psychological harm, and the fact that the available options locally for terminations will reduce as gestational age increases. Arbuthnot J stated that directions hearings should be held within 48 hours of an application being issued, with a final hearing to be listed no more than seven days later.

40. The directions made at the first hearing in this case provided for the Health Board to answer a number of questions that the Official Solicitor had posed, including clarifying whether there would be a deprivation of NN's liberty, and for an independent assessment of capacity to be obtained, with disclosure of NN's medical records to take place by 27 August. In my view, it was unrealistic of the Health Board to think that the final hearing could be listed by 27 August when even the medical records of NN were not immediately ready for disclosure to the Official Solicitor, and their application did not address all the matters which the court would need to consider. If applications are made quickly, in the knowledge that not every piece of evidence is ready, then it must be recognised that final hearings are unlikely to take place within a week of issue. If the application is delayed to perfect the evidence before issuing, a final hearing may be capable of being listed within a week or so of the first directions hearing, but the risk with this approach is that the Official Solicitor may consider that further enquiries are required, going beyond a single visit to P and a review of P's medical records. Given the serious consequences to a patient in NN's position of any delay, it would have been better for the Health Board to issue sooner, so that the investigations of the Official Solicitor could take place alongside the Health Board's provision of more detailed or additional evidence. That accords with the guidance of Cobb J in ***Re PG (Serious***

Medical Treatment) [2024] EWCOP 49 (T3), that NHS bodies should not be concerned with ensuring that that "*every 'i' is dotted and every 't' crossed before making the application where speed of decision-making may be of the essence: perfect in this instance may well be the enemy of the good*".

41. Ms Scott goes on to submit that had the Health Board's application correctly identified the orders it sought, the application could have been dealt with by agreement or on the papers, as the only issue was approval of a possible deprivation of liberty in the event that NN herself chose to proceed with a termination and, part of the way through that procedure, refused to accept medical advice which would put her at risk of serious harm. Mr Jones says that this point has been made in hindsight and was never hinted at by the Official Solicitor during the proceedings. I express no view on whether this case could have been dealt with on the papers, but it does seem to me fair to say that had the application been clearly focused on the limited issue in respect of which the court's intervention was required from the outset, the Official Solicitor's investigations may have been carried out more quickly and agreement reached.

42. Drawing the above together, in my view the Health Board did delay unreasonably in issuing proceedings, and that had a serious negative impact on NN. The negative impact goes wider than just NN. Her mother told the Official Solicitor's caseworker after the procedure that this has been the worst experience of her life and that it was '*absolutely barbaric*'. She was clearly traumatised by watching her daughter having to continue her pregnancy well into the second trimester despite having requested a termination, and then supporting her through a late medical termination which resulted in the baby being born alive. I consider it appropriate to reflect the court's disapproval of the Health Board's conduct in this case and its impact on NN and her family in a costs order. I will direct that the Health Board shall pay 100% of the costs of the Official Solicitor in this application, excluding the costs incurred in relation to the hearing on 20 August 2024 which will be paid at the previously agreed rate of 50%, the order from that hearing having included the following provision: "*No order as to costs, save that the Trust shall pay 50% of the Official Solicitor's costs, to be assessed if not agreed*."

43. A final observation: the application in this case was to authorise a possible future deprivation of liberty which did not, in fact, materialise. It would be reasonable for NN or her mother to ask what purpose was served by the proceedings and what benefit they had for NN. It is incumbent on those concerned with obstetric cases to give the most careful scrutiny at the earliest possible stage to whether orders are actually required from the Court of Protection, and if so, the substance of those orders. In this case, the minutes of various professionals meetings held in June and July 2024 suggest that there was a mistaken belief that any best interests decision about termination of pregnancy for a person without capacity required court authorisation. If there is a professional consensus about the treatment proposed, no intention to impose treatment on P against her wishes, and no disagreement from those concerned with P's welfare such as close family members, the provisions of s.5 and s.6 MCA 2005 permit medical best interests decisions to be taken without court involvement, having followed the requirements of the MCA and any associated professional guidance: ***An NHS Trust v Y*** [2018] UKSC 46.

44. If aspects of a treatment plan may constitute a deprivation of liberty, serious thought must be given to how likely it is that those measures will be needed. Is there evidence suggesting that the particular patient, if they have chosen to undergo a medical

procedure in hospital, and are in need of pain relief and support from medical professionals, will suddenly refuse help even if they are told their health and potentially their life are at risk? Where the patient is in agreement with the underlying treatment, and, as here, is not suffering from persecutory delusions or an ingrained fear of hospitals or medical professionals, what is it that suggests the risk of needing to take such steps is materially different than for a patient who does not have a diagnosed mental disorder and is not detained under the MHA 1983?

45. In ***The Shrewsbury and Telford Hospital NHS Trust v T & Anor*** [2023] EWCOP 20, Lieven J declined to make an anticipatory declaration in respect of a pregnant women detained under the MHA 1983 where there was nothing more than a 'small risk' that she might lose capacity at the time decisions needed to be made about delivery of her baby. Lieven J held that the clinicians could rely on the doctrine of necessity in an emergency, saying "*there needs to be some caution about turning what are in truth medical decisions into legal ones*". I did not hear argument on the question of whether the clinicians in this case could have relied on the doctrine of necessity, or on the provisions of s.4B MCA 2005, which expressly authorises the deprivation of a person's liberty for the purpose of giving a patient life-sustaining treatment or preventing a serious deterioration in their condition while court authorisation for the same is sought. (In the longer term, the revisions to s.4B MCA 2005 in s.2 of the Mental Capacity (Amendment) Act 2019, if implemented, would authorise deprivations of liberty for the purpose of providing life-sustaining treatment in an emergency without requiring the court's authorisation.) These alternative options will need to be considered by health bodies contemplating court applications in future cases such as this, where time is of the essence and every day that passes places a psychological burden on the pregnant woman, and where a future deprivation of liberty is not certain.